Fayette County Public Health
Prevent. Promote. Protect.

CONSENT TO ADMINISTER VACCINE

IF COVERED UNDER MEDICAL INSURANCE, SEND COPY OF CURRENT CARD

SCHOOL NAME:	Grade/HR

PLEASE PRINT PATIENT INFORMATION

STUDENT NAME (Last Name): (First Name): (M.I.):

Date of Birth:	Sex:	Ethnic Group	Parent/Guardian (If different than patient):
	○ Male ○ Female ○ Other	○ Hispanic ○ Non-Hispanic	

Race: ○ Alaskan Native ○ AM-American Indian ○ Asian ○ Black/African American ○ Native Hawaiian ○ Prefer Not to Disclose ○ Unknown ○ White

Street Address:	City:	State:	Zip Code:

Home Phone:	Alternate/Cell Phone:	Email Address:

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone Number: _____

Are we able to leave messages with your emergency contact: ○ Yes ○ No

PRESCREENING QUESTIONS:

Is the person receiving the vaccine(s) well today? ○ Yes ○ No

HAS THE PERSON RECEIVING THE VACCINE(S) HAD (IF YES, PLEASE EXPLAIN BELOW):

1. A severe reaction to vaccines? ○ Yes ○ No
2. A history of seizures / health / immune system problems? ○ Yes ○ No
3. An allergy to food, dye, or medications? ○ Yes ○ No
4. Shots in the last 4 weeks or blood transfusion in the last year? ○ Yes ○ No
5. Treatment by a physician or on daily medication? ○ Yes ○ No
6. Parent / sibling history of seizures or vaccine reactions? ○ Yes ○ No
7. Chicken Pox disease or the vaccine? ○ Yes ○ No
8. Older females only – are you pregnant? ○ Yes ○ No

Explanations:

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Authorization and Consent:

I hereby consent to the use and disclosure of my or my child's personal health information, for the purpose of health care operations, along with the assignment of all payment from the insurer listed to the Fayette County Health District associated with the services delivered. I understand that I will be responsible for any charges incurred by not providing the most current, correct insurance information. If my insurance carrier determines I have not met my deductible or I have a co-insurance, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by my insurer or provider. I assume full responsibility for services rendered to me or my child if my insurance carrier denies or does not cover my claim for these services. This health record may also be released to health care providers, health departments, schools, daycare providers, state immunization registry data bases, and others as is deemed necessary for continuity of care. The Notice of Privacy Practices has been received for Fayette County Public Health; 317 South Fayette Street, Washington CH, Ohio 43160. My signature indicates my understanding of all of the above, and that I have requested that the vaccine(s) indicated be administered to me or my child. I have received the appropriate Vaccine Information Sheet (VIS) and had an opportunity to ask questions and have those questions answered to my satisfaction. For patient safety, due to possible allergic reactions and/or fainting episodes, it is suggested the patient receiving the vaccine(s) sit in the waiting room for 15-20 minutes after receiving the vaccine(s).

Signature: _____

Print: _____

Nurse: _____

Date: _____

Vaccine Given:

Lot Number & Expiration Date:

Location Given:

Nurse Initials: